BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **Betty C. Ashton** **aka Betty Carol Ashton** **460 E. Fer Ave # 207** **Redlands, CA 92373** Registered Nurse License No. 442833 Respondent.	Case No. 2007-16 OAH No. 2007050021

DECISION

The attached proposed decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on **June 5, 2009.**

IT IS SO ORDERED this **5th** day of **May, 2009**.

Susanne J. Phillips, MSN, RN, FNP-BC
Board of Registered Nursing
Department of Consumer Affairs
State of California

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: BETTY C. ASHTON aka BETTY CAROL ASHTON, Respondent.	Case No. 2007-16 OAH No. 2007050021

PROPOSED DECISION

Mary Agnes Matyszewski, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter at Riverside, California on January 26, 2009.

Kathleen Lam, Deputy Attorney General, Office of the Attorney General, State of California, represented complainant Ruth Ann Terry, M.P.H., R.N., Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, State of California.

Donald Hensel, Esq., represented respondent Betty C. Ashton, R.N., who was present throughout the administrative proceeding.

The matter was submitted on January 26, 2009.

FACTUAL FINDINGS

Jurisdictional Matters

1. On July 13, 2006, Ruth Ann Terry, M.P.H., R.N., the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, State of California (Board), signed the accusation in her official capacity.

The accusation alleged that on April 7, 2004, respondent was grossly negligent, incompetent and engaged in unprofessional conduct when she placed a patient in four-point restraints while the patient was in the prone position. Complainant requested that respondent's nursing license be disciplined.

Respondent was served with the accusation and other required jurisdictional documents. She timely filed her notice of defense.

On January 26, 2009, the record in the administrative action was opened. Jurisdictional documents were presented, documentary evidence and sworn testimony were received, closing arguments were given, the record was closed, and the matter was submitted.

Respondent's Licensure

2. On August 31, 1989, the Board issued registered nurse license number 442833 to respondent. That license has remained in force to the present. That license expires on August 31, 2009, unless renewed, suspended or revoked.

There is no history of any discipline having been imposed against respondent's license.

Patient's Medical Background

3. Julian L., a 15-year-old-boy with a history of Down's syndrome, underwent a tonsillectomy/adenoidectomy on March 16, 2004. Julian L. lived with his foster care mother, Elba Martinez, who testified that a few days after this surgery, Julian L. "had some sort of convulsion" at lunch, that she applied the Heimlich maneuver for his choking and called the paramedics. According to Martinez, the paramedics examined Julian but did not transport him to the hospital. Martinez testified that she took Julian to Parkview Hospital on either April 5 or 6, 2004, because he was having breathing difficulties. Julian L. was treated and released. Again, on April 7, 2004, Martinez called the paramedics because of Julian L.'s breathing difficulties. Julian L. was transported by ambulance to Parkview Hospital again.

April 7, 2004, Treatment

4. The Parkview Hospital Emergency Department Report noted a chief complaint of shortness of breath. Julian L. had been treated on April 5, 2004, in the emergency room with similar complaints. Martinez advised that the patient's breathing was "getting worse." A review of the prior ER record indicated that the patient had been uncooperative on the last visit, which prevented adequate assessments from taking place. At this visit the patient was also uncooperative, again making it difficult to examine him.

At 10 p.m. the patient was wildly thrashing and then was observed not breathing. A Code Blue was called and after 45 minutes of resuscitation efforts, Julian L. was pronounced dead. The autopsy report attributed the cause of death to "acute bronchitis, peribronchitis and focal bronchopneumonia."

Patient's Body Position During Placement of Restraints

5. Julian L. was treated in the Parkview Emergency Department, an open area where beds were adjacent to each other. Julian L.'s bed was visible to others in the area including Martinez and several hospital staff.

Martinez testified that Julian L. received one breathing treatment from a respiratory therapist, and that no one else was at Julian L.'s bedside when respondent began placing restraints on him while he was prone. Martinez testified that after respondent restrained Julian L. in the prone position, respondent left the bedside. Martinez then noticed that Julian L. was not breathing and called for help.

Respondent received Julian L. as her patient at 21:40. She testified that Julian was uncooperative; removing diagnostic devices she tried to apply.[1] She decided to apply restraints. Respondent had never worked at Parkview Hospital before, so she asked co-workers where the restraints were stored. Respondent testified she requested assistance with placing the restraints as Julian L. was quite strong. She recalled the charge nurse asking someone to assist her. Respondent testified that Julian L. was in a supine position, moving wildly about the bed, but she was able to place the two ankle restraints and one wrist restraint on him. Respondent had not yet secured any of the restraints to the bed frame. While respondent was squatting down by the side of the bed and was attempting to place the fourth restraint, someone said that Julian was not breathing. Respondent immediately stopped, assessed Julian and called the code. Respondent recorded the code which began at 22:01.

A Respiratory Flowsheet documented that Julian L. received three breathing treatments via mask at 21:38, 21:50 and 22:05.

Respondent completed a statement for her employer the day after the incident occurred. Respondent testified that when her shift ended the morning of April 8, 2004, she called her employer to advise of what had occurred and she was told to come to the office and fill out a statement, which she did before going home. In that statement, respondent wrote that she called for help in placing the restraints and that the charge nurse instructed the ER tech, Jeff, to assist her. Respondent stated that she had not secured any of the restraints to the bed frame, only to Julian's two ankles and one wrist, and that when she was placing the fourth restraint she heard someone state, "He's not breathing." Respondent stated that she immediately untied Julian L. and "log rolled" him to check for respirations.

Expert Testimony

6. Kimberlee Van Der Kolk, R.N., testified for complainant. She received a bachelor's degree in Nursing from Mount St. Mary's College in 2002, a nurse practitioner certificate in May 2005, and a master's in Nursing in December 2005. She works as a nurse at Presbyterian Intercommunity Hospital.

Van Der Kolk authored a report wherein she concluded that using restraints on a prone patient constituted gross negligence, incompetence and unprofessional conduct. She admitted that she did not review the autopsy report before writing her report. Van Der Kolk also admitted that she never interviewed respondent and that she had not been provided with

[1] The admitting notes from the ER physician also document that Julian L. was uncooperative with staff members trying to assess him in the ER.

all of the documents provided to respondent's expert. When questioned about the coroner's findings, Van Der Kolk admitted that those conditions referred to in the autopsy report take a few days to develop. Van Der Kolk also admitted that she had assumed the patient was prone when she formulated her opinions, but she did not clearly explain the reason for that assumption.

7. Laura Burchell-Henson, R.N., R.C.P., has been licensed as a respiratory therapist since 1983 and has been licensed registered nurse since 1990. Burchell-Henson has also been a certified legal nurse consultant since 1998 and has been employed as a certified critical care nurse since 1992. In addition to medical-legal work, Burchell-Henson works at Alvarado Hospital as an interventional radiology nurse. She reviewed all of the medical records, including the autopsy report, and she had also interviewed respondent.

Burchell-Henson testified that her review of the records indicated that at no place in those records did anyone ever indicate that the patient was "prone." Martinez stated that Julian L. was "face down," Parkview's risk manager wrote in her report that he was "on his stomach" and respondent stated he had "flip flopped onto his abdomen," none of which described a true prone position and all of which were consistent with the restraints being applied in a supine position, with Julian L. twisting and turning as he fought those restraints.

Burchell-Henson opined that in order for Julian L. to have been prone, one would have to believe that all of the other individuals present in the ER and those who assisted in Julian L.'s treatment did nothing while he was restrained in a prone position. Burchell-Henson testified that this event simply was not likely. There were too many people in the ER and an individual was assisting respondent in placing the restraints. She believed it highly unlikely that such a skilled person would allow improper restraints to be placed. Additionally, Burchell-Henson testified that the three breathing treatments would necessarily have been administered in the supine position and the last treatment occurred at or near the time the patient stopped breathing. A licensed respiratory therapist likely would not have permitted prone restraints to be placed on Julian L.

Burchell-Henson prepared a DVD demonstrating how respondent's version of events could have occurred. On that DVD a "patient" is seen thrashing wildly back and forth, from side to side and almost attaining a prone position even though the restraints are being applied in the supine position. The DVD convincingly supported respondent's version of events.

Respondent's Testimony

8. Respondent was a very credible witness. She obtained her LVN license in 1985 and her RN license in 1989. She has worked at Riverside City Hospital, Riverside Regional Medical Center, in both OB and ICU, at the UCSD Burn Center. Since 2004, she has been an employee of Maxim, a nurse registry. Prior to treating Julian L., respondent received training in both nursing school and at hospitals concerning the proper use of restraints. She has used restraints over 1,000 times in her career. Respondent knew that restraints are never to be applied to a patient in a prone position and she believably recalled that she did not do so in this case.

Respondent credibly explained that her statement to the Board, which she signed but did not draft, stated that the patient was on his stomach, but she does not use the word "stomach" in her own reports, instead she uses abdomen. Respondent told the investigator that the patient kept rolling onto his side while she was restraining him, but she never stated that the patient was prone during application of the restraints. Respondent testified about Julian L.'s refusal to permit respondent to treat him, which was amply supported by the records and the notes of other treaters. Moreover, respondent's testimony was consistent with her previous statements, some almost five years old, and those areas in which her testimony differed were well explained and did not establish an attempt to deceive. Respondent credibly explained that "log roll" did not mean the patient was completely prone, rather that he was on his side, almost to his stomach.

Evaluation

9. Placing a prone patient in restraints is below the standard of care. Thus, the issue was whether Julian L. was prone when respondent placed him in restraints. The evidence was not clear and convincing that Julian L. was in a prone position when respondent applied the restraints.[2]

Respondent treated Julian in the emergency room, an open area where treaters can easily view the patients. An ER technician assisted respondent in the placement of the restraints. From all accounts, the ER technician was not interviewed regarding Julian L.'s position when respondent placed the restraints. Absent his statements to the contrary, it is difficult to imagine that the ER technician would stand idly by and allow the restraints be placed while the patient was prone. The records were replete with the names of others who were present in the ER; none of them were interviewed. Again, it seems implausible these persons they would have permitted improper restraints to be applied. Julian L. received three breathing treatments which could only occur in the supine position, and the last treatment was administered at or near the time Julian L. coded.

When the code was called, several treaters arrived in the Emergency Room and became involved in Julian L.'s care; not one of them reported that the restraints were improperly placed. Complainant lacked sufficient evidence to rebut respondent's testimony. Nothing in the final ER report or the autopsy report mentioned anything about the restraints, nor attributed the cause of death to them. The DVD prepared by respondent's expert convincingly demonstrated how patient who was thrashing could get to his side or stomach while restraints were being placed properly. Finally, while Martinez testified that Julian L. was prone when respondent placed Julian L. in restraints, her testimony regarding the other treatment Julian L. received and who was present when he coded was inconsistent with many other sources of information, raising questions about her memory and the accuracy of her testimony. In light of all the evidence that was presented, it was much more likely than not that respondent properly applied the restraints.

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[2] There was no issue regarding the decision to use restraints as the evidence demonstrated that Julian L. was uncooperative and would not allow assessments to be taken, requiring restraints be used.

Finally, respondent's expert's opinions were more persuasive because she had reviewed all of the documents at issue, whereas complainant's expert had not done so. Respondent's expert conducted a thorough review of the records and she convincingly explained how the assumption the patient was "prone" was made and how the evidence did not support that assumption. Complainant argued that its expert was prohibited from performing certain activities that respondent's expert performed in evaluating the evidence, but the thoroughness of complainant's expert's investigation only served to make respondent's expert more reliable than complainant's expert. Complainant also argued that respondent's expert was a "professional witness," but the fact that respondent's expert reviewed all the documents and made a careful review of them demonstrated that she was much less an advocate than complainant's expert, who was willing to express an expert opinion on the limited evidence made available to her. Respondent's expert was both credible and convincing.

Cost Recovery

10. A certification of prosecution costs and a declaration prepared by complainant's attorney were introduced. Those documents established that approximately 131 hours of attorney and paralegal services were billed by the Attorney General's Office at hourly rates between $101 and $158 per hour. A declaration by the investigator was introduced which indicated that 52.25 hours were spent at rates between $161 and $180 per hour. Total costs of investigation and prosecution being sought were $29,081.75. However, as complainant failed to meet its burden of proof, no finding about the reasonableness of those costs will be made as no costs will be awarded to complainant.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856, holds that "clear and convincing proof to a reasonable certainty" applies in disciplinary proceedings seeking to revoke or suspend a professional license.

Relevant Statutory Provisions

2. Business and Professions Code section 2761 provides in part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

Relevant Regulations

3. Title 16, California Code of Regulations, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

4. Title 16, California Code of Regulations, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse . . ."

Cause Does Not Exist to Impose Discipline

5. The clear and convincing evidence did not establish cause to impose discipline under Business and Professions Code section 2761, under Title 16, California Code of Regulations, sections 1442 or 1443. It was not established that respondent applied restraints when Julian L. was in a prone position.

This conclusion is based on Factual Findings 1-9 and on Legal Conclusions 1-4.

The Award of Reasonable Costs

6. Business and Professions Code section 125.3 permits the Board to seek its reasonable costs. Here, as complainant failed to meet its burden of proof, no determination of reasonableness is necessary as no costs shall be awarded.

This conclusion is based on Legal Conclusion 5.

ORDER

IT IS HEREBY ORDERED that Accusation No. 2007-16 filed against Betty C. Ashton, aka Betty Carol Ashton, is dismissed.

DATED: 2-23-09

MARY AGNES MATYSZEWSKI
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **BETTY C. ASHTON** **a.k.a. BETTY CAROL ASHTON** 11171 Oakwood Drive, Apt. E101 Loma Linda, CA 92354 Registered Nurse License No. 442833 Respondent.	Case No. 2007 - 16 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about August 31, 1989, the Board issued Registered Nurse License Number 442833 to Betty C. Ashton, also known as Betty Carol Ashton ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2007, unless renewed.

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STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> "The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> "(a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> "(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .
>
> " . . . ."

6. California Code of Regulations, title 16, section ("Regulation") 1442 states:

> "As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

7. Regulation 1443 states:

> "As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

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COST RECOVERY

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. In or about April 2004, Respondent was employed as a registered nurse by NOW Nurses Registry, Yorba Linda, California, and was assigned to work in the Emergency Room ("ER") at Parkview Community Hospital Medical Center, Riverside, California.

10. On April 7, 2004, Patient Julian L., a 15 year old male with a history of Down's syndrome and an unspecified heart disease requiring open heart surgery, was taken by ambulance to the medical center with complaints of shortness of breath.[1/] The patient arrived in the ER at approximately 2100 hours and was lying supine on the hospital gurney. Respondent was the primary nurse for the patient. Medical staff, including Respondent, attempted to place the patient on the cardiac monitor and pulse oximetry machine to measure his heart rate, heart rhythm, and oxygen saturation; however, the patient was noncompliant with the staff's efforts. Respondent and the patient's caregiver attempted to calm and comfort the patient. Despite the efforts of the medical staff and the caregiver, the patient remained agitated and noncompliant, requiring the administration of medication via intramuscular injection in an effort to calm the patient. The patient continued with his agitation and eventually turned himself over on the gurney into the prone position.

11. At approximately 2200 hours, Respondent began placing the patient into four-point restraints. At approximately 2201 hours, while placing the fourth and final restraint on the patient, Respondent noticed that he had stopped breathing. Respondent called a "Code

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1. Patient Julian L. had undergone a tonsillectomy/adenoidectomy on March 16, 2004, at another facility. The patient suffered complications from that surgery and was treated in the intensive care unit for seven days with a diagnosis of pneumonia.

White"[2/]. Dr. Michael R. arrived at the patient's bedside and found the patient breathing with agonal respirations, a slow, irregular heart rate, and no significantly palpable pulses. Dr. R. ordered the medical staff to start cardiopulmonary resuscitation ("CPR") and advanced cardiac life support ("ACLS") and inserted a breathing tube into the patient's trachea to assist with CPR efforts. ACLS was continued, including the administration of intravenous ("IV") medications once IV access was gained. As the patient's condition deteriorated, one precordial thump was performed by Dr. R., followed by electrical defibrillation according to ACLS protocols. The patient's cardiac rhythm continued in asystole, and Dr. R. ordered the staff to end ACLS efforts. The patient was pronounced dead at 2248 hours by Dr. R.

12. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that she was guilty of gross negligence in her care of Patient Julian L. within the meaning of Regulation 1442, as follows:

a. Respondent applied physical restraints to Patient Julian L. while he was in the prone position.

b. Respondent failed to adequately assess Patient Julian L. after placing him in physical restraints while he was in the prone position, even though Respondent knew that the patient was admitted to the ER for shortness of breath.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

13. Complainant incorporates by reference as if fully set forth herein the allegations contained in paragraphs 9 through 11, above.

14. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct. On or about April 7, 2004, while on duty as a registered nurse in the ER at Parkview Community Hospital Medical Center,

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2. A "Code White" indicates respiratory and/or cardiac arrest in a child.

Riverside, California, Respondent was guilty of incompetence in her care of Patient Julian L. within the meaning of Regulation 1443, as set forth in subparagraphs 12 (a) and (b) above.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

15. Complainant incorporates by reference as if fully set forth herein the allegations contained in paragraphs 9 through 11, above.

16. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), in that on or about April 7, 2004, while on duty as a registered nurse in the ER at Parkview Community Hospital Medical Center, Respondent committed acts constituting unprofessional conduct in her care of Patient Julian L., as set forth in subparagraphs 12 (a) and (b) above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 442833, issued to Betty C. Ashton, also known as Betty Carol Ashton;

2. Ordering Betty C. Ashton, also known as Betty Carol Ashton, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 7/13/06

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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